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AUTHOR Roat, Lenora L.
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ABSTRACT

This document reviews outcome studies on the long- and short-term treatment of depression and critiques the methodologies used in these studies. Twenty-four studies comparing length of treatment and outcome of psychotherapy are included in the review. The majority of the studies reviewed involved individual adult outpatients as subjects. The terms "psychotherapy," "therapy," and "treatment" are used interchangeably; no distinction has been made between different types of long-term or short-term therapy. Because various researchers have defined short-term therapy as lasting anywhere from two sessions to less than 6 months and long-term therapy as anywhere from nine sessions to 24 months, there was considerable overlap of time where therapy could have been considered either long- or short-term depending on the particular researcher; consequently, the definitions of short- and long-term treatment used in this review correspond to what each individual investigator considered to be short- or long-term. The studies reviewed suggest that both long- and short-term therapies are effective in the treatment of depression and that there are many other factors which influence the outcome of psychotherapy. The review concludes that, since a history of depression, biological factors, the presence of few or many treatment issues, overall level of psychological health, and severity of the present symptom all contribute to the success of therapy, these factors need to be considered in referring patients for appropriate treatment. (NB)

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A REVIEW OF THE EFFECTIVENESS OF LONG-TERM VERSUS SHORT-TERM THERAPY IN THE TREATMENT OF DEPRESSION

A Doctoral Research Paper

Presented to

the Faculty of Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Lenora L. Roat

May 1992

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by

Lenora L. Roat

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First Reader

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Second Reader

APPROVED:

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ABSTRACT

A REVIEW OF THE EFFECTIVENESS OF LONG-TERM VERSUS SHORT-TERM THERAPY IN THE TREATMENT OF DEPRESSION

by

Lenora L. Roat

Research relevant to the comparison of outcome studies on long- and short-term treatment of depression is reviewed, and their methodology critiqued. Research suggests that both long- and short-term therapies are effective in the treatment of depression and that there are many other factors which influence the outcome of psychotherapy. A history of depression, biological factors, the presence of few or many treatment issues, overall level of psychological health, and severity of present symptoms all contribute to the success of therapy. These factors need to be considered in referring patients for appropriate treatment.

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A Review of the Effectiveness of Long-Term Versus Short-Term Therapy In the Treatment of Depression

Introduction

There has long been controversy regarding the efficacy of psychological treatment. Since the 1950s, when research on the process and outcome of therapy began to accelerate, various psychological theorists and researchers have fine-tuned, classified and diversified psychotherapeutic forms. Currently there are many different theories about what does and does not work in therapy (Orlinsky & Howard, 1986). Prejudices survive regarding the length and type of treatment that is most effective, and they usually seem to correlate highly with the training and preferred modality of the individual presenting his or her case (Ursano & Dressler, 1977). This conflict has been intensified recently due to various changes in the economic climate of our society.

In recent years, one debate concerning the effectiveness of various psychotherapy treatment modalities has focused on the length of time in treatment. There has been a growing interest in short-term treatment and more economical forms of psychotherapy (Piper, Debbane, Bienvenu, & Garant, 1984). Research in this area is becoming more important for several reasons. The demand for psychological services continues to rise as psychotherapeutic treatment becomes more acceptable, while therapists are still limited in the number of

patients they can treat at one time (Kovacs, Rush, Beck, & Hollon 1981). The cost of treatment also continues to rise despite economic recession. Insurance companies continually seek ways to limit their expenses by removing mental health treatment from their coverage, by limiting the number of sessions allowed per year, or by establishing a dollar limit per claimant each year. The reasoning behind these limits is often based on research showing the effectiveness of short-term treatment (Lesser, 1979; Sharfstein & Magnas, 1975). Thus, it is important to examine this body of research for its soundness and implications. Those trained in long-term therapies tend to view time as an important factor in the healing effects of treatment while those trained in other modalities tend to believe that factors other than time are more important to the success of therapy. Piper et al. (1984) pointed out that short-term therapy does not simply mean less of long-term therapy. Often, differences in the length of treatment believed necessary for success are based on differing theoretical approaches to mental illness and treatment. The proponents of each theory may have invested their economic security as well as their personal self-esteem in the efficacy of the treatment they propose. Therefore, it is up to objective parties to determine the reliability of the research upon which are based the kinds of decisions which affect the future of a client's mental health treatment. There have been a number of studies comparing length of treatment and outcome of psychotherapy, 24 of which are reviewed here. Few researchers have focused on specific diagnoses, although most theorists suggest the use of specific selection criteria (including diagnosis)

when determining whether or not a particular therapy modality is expected to be beneficial to a particular client (Errera, McKee, Smith, & Gruber, 1967; Marmor, 1979; Stewart, 1972; Terestman, Miller, & Weber, 1974).

Depression is a common diagnosis and of great concern to third party payors since it makes up a large portion of the claims presented to insurance companies. Therefore, it makes economic sense to focus in particular on its treatment. There are many theories about depression and its treatment (Akiskal & McKinney, 1975; Stricker, 1983). The etiology and manifestation of depression may have particular effects on its treatment and resolution; these are examined as they relate to the research presented.

The purpose of this paper is to examine the results and implications of research on the length of time necessary for successful treatment of depression using psychotherapy. The paper discusses difficulties affecting outcome research in psychotherapy for depression, the results of recent studies and recommended directions for future research and the training of therapists.

Constraints of the Literature Review

Studies on depression included in the present paper were located through a search of Psychological Abstracts and through manual searches of relevant references in the literature. Studies were selected first on the basis of their comparison of long- and short-term treatment and then on the basis of their relevance to the treatment of depression. Of the sources used, 56% were

empirical studies or meta-analyses from the years 1970 - 1991. The 24 studies examined in the present review involved individual adult outpatients, with the exception of the Glick, Hargreaves, Drues, & Showstack (1976a, 1976b, 1976c) studies and the Glick, Hargreaves, Raskin, & Kutner (1975) study which used an inpatient population, and a study by Kissel (1974) which used children as subjects. Wherever possible the results pertaining to patients diagnosed as depressed have been extracted.

Definition of Terms

For the purposes of this review the terms "psychotherapy," "therapy" and "treatment" have been used interchangeably. No distinction has been made between different types of long-term or short-term therapy. The studies reviewed for this paper consisted of research on individuals in psychotherapy, and thus when the term "group" is used it refers to those groups of clients or patients assigned to long- or short-term individual therapy. Various researchers have defined short-term therapy as anywhere from "two sessions" (Weitz, Abramowitz, Steger, Calabria, Conable, & Yarus, 1975) to "less than six months" (Stewart, 1972). Long-term therapy has been defined as anywhere from "nine sessions" (Keilson, Dworkin, & Gelso, 1979; Munro & Bach, 1975) to "24 months" (Piper et al., 1984) or "unlimited" (Burlingame & Behrman, 1987). There was a considerable overlap of time between nine sessions and six months where therapy could have been considered either long- or short-term depending on the particular

researcher or author. For the purposes of the present review no attempt has been made to synthesize the time limits in therapy, but the definition of short- and long-term treatment corresponds with what each individual investigator considered to be short-term or long-term.

Depression can have varied meanings. For instance, it can refer to mood, clinical syndrome, primary feeling, character structure, biochemical disease, response to crisis, or life style (Stricker, 1983). For the purposes of this paper, however, the term depression refers to a clinical diagnosis of a depressive disorder.

Difficulties in Evaluating Relevant Research Studies

Confusion in Terms and Definitions

There are several difficulties unique to research comparing long-term versus short-term treatment of depression. For instance, it is difficult to compare different studies because in discussing short- and long-term treatment, many researchers have used various terms in reference to similar concepts without defining them. For example, Burlingame and Behrman (1987) referred to time-limited and time-unlimited treatment. The reader should be aware of the differences between some investigators (Kissel, 1974) who have claimed that the difference between long- and short-term treatment is in the theoretical or conceptual attitude and approach to treatment contrasted with others who claim the difference is in the actual length of time spent in therapy. The term

exploratory therapy has usually referred to long-term therapy while the term supportive has often been used to refer to short-term therapy. The terms non-focal or multi-focal have been used to imply the use of long-term treatment while the term focal has implied the use of short-term treatment (Errera et al., 1967; Ursano & Dressler, 1974). Cummings (1977b) called long-term therapy prolonged or "ideal" and short-term therapy "realistic" psychotherapy. From these terms the impression can be given that long-term therapy is seen as unrealistic, particularly in light of the demands of current economic and time restraints.

Smith and Glass (1977) argued that "all outcome measures are more or less related to well-being and so at a general level are comparable" (p. 753). Other investigators have seen the issue quite differently. They have reported that most of the research has emphasized those criteria for success associated with the goals of short-term treatment (Burlingame & Behrman, 1987; Frank, Jarrett, Kupfer, & Grochocinski, 1984; Garfield, Prager, & Bergin, 1971; Glick, Hargreaves, Drues, & Showstack, 1976a, 1976b, 1976c; Glick, Hargreaves, Raskin, & Kutner, 1975; Hill, Carter, & O'Farrell, 1983; Keilson et al., 1979; Stewart, 1972; Weitz et al., 1975). There have been few studies on the distinctive goals associated with long-term therapy (Brockman, Poynton, Ryle, & Watson, 1987; Piper et al., 1984; Strassberg, Anchor, Cunningham, & Elkins, 1977; Ursano & Dressler, 1977;), and those studies which did emphasize these goals have tended to get swamped in the meta-analyses by research on short-term therapy. The more focused goals of short-term treatment appear to make it easier to measure change. Long-term

dynamic theorists have been accused of having a bias against research and of seeming to feel that research is of lesser importance. The goals of dynamic therapy appear more difficult to quantify, thereby making change more difficult to measure (Johnson & Gelso, 1979). If this is true, then it is likely that the results of the research will be biased toward the apparent success of short-term therapy.

Defining what constitutes success, improvement and/or cure creates further difficulties in evaluation of depression research. Different criteria for evaluating improvement may be used by therapists, by clients, or by researchers, thus making the interpretation of results at best rather tenuous. The client may simply feel better and thus report improvement, while the researchers' testing shows that symptoms have not been reduced (Johnson & Gelso, 1979). The question then arises as to whose definition should be used. Long-term therapists, especially those who are more analytically-oriented include "personality changes" as part of their definition of improvement and attempt to treat the depressed person as opposed to his or her symptoms. The theory behind this long-term approach is that the presenting symptom is intertwined with an intrapsychic and interpersonal context and can only be handled by attention to that context (Akiskal & McKinney, 1975; Stricker, 1983). This definition is so diffuse that change is difficult to identify, quantify and measure. The goals of short-term therapists tend to be much more identifiable and measurable since they often focus more on symptom reduction, thereby making the outcome of treatment easier to establish (Johnson & Gelso, 1979). Long-term therapists also may look for symptom

reduction, but in the deeper internal psychic structures of the personality. The definition and measurement of these constructs present significant hurdles for researchers.

Even with the current Diagnostic and Statistical Manual of Mental Disorders--Revised (DSM III-R, 1983), getting theorists and therapists to agree on diagnoses of various patients remains complicated. This poses a particular problem for outcome research since the comparison of improvement must start with a comparison of dysfunction (Akiskal & McKinney, 1975). It is difficult to measure the differences in degree of impairment at both the onset and termination of treatment. Two clients may be diagnosed with depression but may have very different internal and external manifestations. It has been suggested that the patient's impairment level at the beginning of therapy will likely influence the course of treatment and consequent outcome. This does not mean that therapy has not been effective, but for some people a longer time in treatment may be necessary due to the severity of their impairment or to its unique manifestation. As this is not considered in designing research, the results may therefore be clouded (Johnson & Gelso, 1979; Keilson et al., 1979).

Another problem is that research does not always differentiate between the influence of the passage of time per se and time in treatment. Some research has shown that for some patients, symptoms may abate over time even without treatment. Thus, it is not always clear if it is the treatment being evaluated that is responsible for symptom reduction. Comparisons need to be made at similar

stages in treatment, such as at termination and at follow-up. When a client in short-term treatment is terminating, a client in long-term treatment may still be in the beginning stages of therapy. Thus it would be considered unfair to compare the progress of both clients at that specific point in time. This factor complicates the evaluation of results when comparing long- and short-term treatment modalities (Johnson & Gelso, 1979).

Methodological Difficulties in Outcome Studies

Nature of Measures Used

The most problematic aspects of outcome research in psychotherapy are methodological in nature. Several investigators (Garfield, 1986; Johnson & Gelso, 1979) have conducted extensive studies specifically about these types of problems.

For several reasons, it is problematic that many outcome studies rely exclusively on subjective or self-report measures to determine the success of treatment (Stewart, 1972; Ursano & Dressler, 1977; Weitz et al., 1975). First, clients may see improvement differently based on their reasons for seeking treatment. Johnson and Gelso (1979) found that diagnosis affects clients' satisfaction with treatment. Neurotics tend to see themselves as more improved with longer treatment while psychotics' ratings do not show improvement with more time in treatment. Second, client ratings may be influenced by a "ceiling effect" in which after a certain time in therapy the amount of a client's felt improvement or relief reaches a plateau. Therefore ratings of specific problem

relief may be high while other areas such as self-respect and interpersonal relationships may take longer to validate improvement (Johnson & Gelso, 1979). Third, clients may rate the success of therapy higher, wanting to appear more healthy or more socially desirable (Kazdin, 1980, p. 231). Such impression management may mask whether treatment has truly been effective. Especially in long-term treatment, attrition often becomes a problem. It becomes difficult to measure the amount of improvement since only partial groups remain when treatment is completed (Garfield, 1986). This may represent a bias in the results of outcome research since clients who drop out of long-term therapy cannot be evaluated. Therapy may or may not have resulted in improvement in these cases as it is not clear whether the client dropped out because of improvement in his or her symptoms or for other reasons.

Therapists and clients may use completely different criteria for determining improvement (Kazdin & Wilson, 1978). The client may rate therapy as very successful because he/she feels better, while the therapist may rate it lower because he/she believes improvement means deeper changes in the client than have yet occurred. Johnson and Gelso (1979) noted that findings of outcome research related to time in treatment "predominantly indicate that more treatment yields greater improvement" (p. 73). But when the findings were categorized by the source of the outcome measurement, client ratings showed little relationship to the duration of treatment while counselor and observer ratings were positively related to the length of treatment. The cause of this discrepancy is unclear.

Observers' ratings, while seemingly more objective than those of therapists or clients, are still subject to difficulties when comparing the outcome of long- and short-term therapies. Johnson and Gelso (1979) theorized that the type of behavioral change observable to an objective observer may require some time after the beginning of therapy to manifest itself. Long-term therapy allows this time for change within the treatment, while in short-term therapy the process of change may only begin during the treatment phase and progress may continue unobserved after termination. Observers may not be aware of the changes being sought by the client and thus may miss subtle or internal changes while anticipating only behavioral differences. Some changes are so subjective they may only be seen by an intimate of the client.

One of the problems in using testing to measure outcome success is that the tests are often insensitive to the types of changes being sought. Tests of outcome are less frequently related to duration than are other types of outcome criteria. According to Johnson and Gelso (1979), "studies which used several types of outcome measures found positive relationships between improvement and treatment time when non-test measures were used but not when tests were used" (p. 73). The difference was found to be attributable to the source of the outcome measure used. Outcome measures are often not specifically related to the types of changes sought but tend instead to rate improvement more globally.

Timing of Measurement

The time of measurement is also a source of difficulty in research comparing long-term versus short-term treatment of depression. Most studies use a termination evaluation, though such evaluation cannot reveal the lasting effects of treatment. Follow-up studies are helpful in revealing whether improvements have been maintained over time, but follow-up studies are notorious for the problems they create. Tracing clients over long periods of time can be very difficult, even during the course of ongoing treatment. Finding the client after a long period of time is even more problematic at follow-up. Other variables may interfere with obtaining true results of the original treatment, as when a client has obtained further treatment before being contacted for the follow-up study. Other life circumstances, if only the passage of time itself, may also interfere with evaluation (Johnson & Gelso, 1979).

Other difficulties with research comparing long-term versus short-term treatment of depression arise from the pre-selection of clients for treatment based on diagnosis or other variables. Both psychoanalysis and some short-term therapies specify the "type" of clients appropriate for treatment (Marmor, 1979; Terestman et al., 1974). This makes comparison based on time difficult since it is harder to sort out time as a pure variable. The lack of control groups in many studies can also make the results of long-term versus short-term treatment research questionable (Johnson & Gelso, 1979). Only three studies (Gallagher-Thompson, Hanley-Peterson, & Thompson, 1990; Keilson et al., 1979;

Kovacs, Rush, Beck & Hollon, 1981) reviewed for the present paper included control groups. All of the studies consulted have been evaluated for methodological soundness, and the seriousness of their errors has been considered in discussing the strength of their conclusions. The most thorough studies have used a combination of sources and times of measurement as well as a control group.

Theories of Depression

An understanding of the different conceptualizations or theories regarding depression, its manifestation and its etiology, is necessary in evaluating research regarding optimal treatment of this pervasive condition. Failure to recognize and treat depression appropriately can have tragic results for the suffering client (Stricker, 1983). Atwood and Chester (1987) discussed two basic types of depression: (a) exogenous, and (b) endogenous. Exogenous depression is precipitated by external stress, loss, or crisis. That is, something in the environment contributes to a person's feelings of worthlessness and guilt and thus precipitates a depressive episode. On the other hand, endogenous depression is caused by something unrelated to external factors, e.g., biochemical or hormonal. This is usually the case in bipolar disorders or post-partum depressions. Medication is usually required for proper treatment of endogenous depression.

Correct diagnosis is critical in order for the clinician to gain a clear understanding of the client's presenting issues and to be able to form a coherent

plan for treatment (Stricker, 1983). The theories on depression noted above are simply different ways of looking at a very complex clinical phenomenon. It is necessary to recognize that because of the space limitations of this paper, the theories discussed are simplified brief synopses of various theoretical orientations. Psychodynamic theory of depression includes the idea that the presence of unresolved ambivalence toward the client's parents and his or her inability to express hostility result in internal conflict. The person's rage is then directed inward for fear of losing the parents' love were this rage expressed. The client then experiences a sense of loss in giving up his or her real self in order to preserve the object, grieves for the loss of the self and experiences pain caused by the discrepancy between the actual and ideal self-representation (Atwood & Chester, 1987).

Social learning theory suggests that people become depressed because of social rewards they receive from others when they appear dejected. Learned helplessness is another aspect of this theory in which people are confronted by an uncontrollable and painful series of events which leads them to believe they will suffer no matter what they do. As children, individuals are helpless and feel overwhelmed unless they are taught to cope. Many depressives have never acquired the social skills they need to ensure the possibility of positive reinforcement and thus avoid the overwhelming sense of hopelessness that leads to depression (Atwood & Chester, 1987).

Beck's cognitive theory infers that because people have faulty logic they easily misinterpret events to fit into their negatively distorted belief pattern in which they see themselves as worthless, unlovable and incompetent. These negative beliefs lead to depression (Atwood & Chester, 1987).

Biological theories of depression include the idea that for the brain to function properly, neurotransmitters must be released at certain rates. Too much or too little of these biochemicals, among them serotonin, noradrenaline or norepinephrine, results in depressive symptoms (Atwood & Chester, 1987; Miller, 1981).

There are three components of depression included in these various theoretical orientations: (a) symptom formation, (b) impact on social and interpersonal relations, and (c) personality dynamics. Stricker (1983) went on to suggest that (a) medication may be effective in dealing with symptom formation but not with social and interpersonal relations or personality; (b) short-term therapy may focus on social and interpersonal relations, though it does not intend to and does not affect character structure; and (c) long-term therapy deals with personality dynamics but at times may not address symptom formation.

Implications of Research Reviewed

Process of Therapy

It is possible that differences exist between long- and short-term therapeutic processes. Several authors whose research was reviewed obtained

results which support this idea. Piper et al. (1984) suggested that in long-term therapy patients defend against active involvement in the therapy session. Therapists saw patients acting as if they had plenty of time to work, with the result that the therapists themselves were not satisfied with the outcome of treatment. Piper and associates concluded that short-term work facilitates an atmosphere of time pressure that helps patients to focus and concentrate their attention in therapy. In conjunction with the idea of focusing on particular issues for treatment, other researchers (Hill et al., 1983) have concluded that relapse among patients in short-term therapy occurs because there are too many overlapping issues to deal with, thus making focusing difficult. Several other researchers have also discussed "focal" versus "multi-focal" therapy (Errera et al., 1967; Ursano & Dressler, 1974). Short-term therapy is often seen as most beneficial when there are either one or only a few focal issues that can be addressed.

Other differences have been observed in the way clients have responded to the therapeutic process in long- and short-term therapies. Long-term patients were more likely to comprehend and use the therapists' attempts to clarify and interpret material. In the Errera et al. (1967) study, long-term signified 21 or more sessions, and short-term 6-10 sessions. When short-term therapy was defined as 15 or fewer sessions and long-term defined as 20 or more sessions, therapists and clients who participated in long-term therapy were significantly more in agreement about what the goals were for each therapy session and about their feelings toward treatment and toward each other. Long term therapists and

their clients tended to view each other's behavior more congruently than did those in the short-term group. Therapists and clients in long-term treatment dyads displayed more similar affective responses to the process and course of the therapy sessions. Short-term treatment dyads viewed support (e.g., being treated with understanding, encouragement) and conformity (e.g., doing what is socially correct, accepted and proper) as more important than did long-term dyads. Horn-George and Anchor (1982) and Luborsky, Chandler, Auerbach, and Cohn (1971) suggested that the nature of short-term therapy, which they defined as having less depth and greater orientation toward problem-solving, may make similarity of certain values important for effective therapy. These authors suggested that clients in short-term therapy need to be engaged quickly in the therapy process. Clients' willingness to cooperate may be affected by the importance they place on conformity and support and by how much they believe these qualities to be present in treatment.

Some variables of the therapeutic process that may account for differences in outcome in short- and long-term psychotherapy for depression have been discussed briefly. The question regarding the appropriate treatment for depression reduces to a choice between process versus time. The studies cited above seem to suggest that there are differing processes that take place in various therapeutic modalities. Only one study reviewed for the present review (Rounsaville, Wiessman, & Prusoff, 1981) could be construed as suggesting that time itself may be part of the necessary ingredients for therapy to be successful in

the treatment of depression. Using short-term interpersonal psychotherapy, Rounsaville and associates found that there was no significant relationship between the client's degree of reflectiveness and the outcome of therapy, nor was there a significant relationship between the therapist's use of "psychodynamically oriented exploratory" techniques and the success of treatment. They stated that "psychotherapy is effective through non-specific aspects of treatment" (p. 73). That is, time was an important variable in the therapeutic process that occurred during a particular period. Time was a better predictor of outcome than were the various therapeutic techniques employed.

Therapist Evaluation and Outcome

Apparent differences in outcome results for patients in short- or long-term treatment groups have often depended on the source of the evaluation. In two studies of therapists using both short- and long-term methods, therapists reported long-term therapy to be most effective in treating neurotic depression (Burlingame & Behrman, 1987; Ursano & Dressler, 1977). Clinicians did not report any difference in the overall value and patient benefit between long- and short-term psychotherapy, but they did see these treatments as differentially efficacious depending on the patient's diagnosis. In another study by Kissel (1974), therapists rated long-term treatment as more effective in the treatment of children, although in the study no differentiation was made based on diagnosis.

Client Evaluation and Outcome

Goyne and Ladoux (1973) had adult clients who completed short-term therapy respond to a survey. Seventy-seven percent of those surveyed indicated that treatment helped them with their presenting problem. Fifty-three percent indicated that treatment was "long enough," while 44% percent said that treatment "needed to be longer." This seems to suggest that although a majority of these clients claimed to have been helped, through short-term therapy, they were divided on whether treatment had been of a sufficient duration.

In three other studies, when clients' levels of satisfaction with long- or short-term therapy were compared, some clients felt short-term therapy to be more beneficial (Piper et al., 1984) while others reported more extensive treatment as more helpful (Weitz et al., 1975). Unfortunately, neither study specified the relative percentages for the two treatments. According to Kissel (1974), parents of children in therapy reported that the number of sessions was not related to the effectiveness of therapy.

Garfield, Prager, & Bergin (1971) found that for both clients and therapists, as well as clinical supervisors, the length of treatment was significantly associated with ratings of change, though this was not supported by other outcome measures. In depression, the client may begin to feel the depression lifting, or the therapist (and consequently the supervisor) may know the client intimately enough to be aware of these more subjective changes and thus be able to note improvement that was not overtly observable or testable. Johnson and Gelso (1979) found that

clients and therapists were subjectively attuned to change to which other outcome criteria were insensitive. They concluded that measures they used were not sensitive enough to detect some aspects of change.

Time of Measure and Outcome

In some cases, differences were also noted between outcome results at the time therapy was terminated and at the time of follow-up. This was especially noted in the four studies of inpatient adults (Glick Hargreaves, & Raskin, et al., 1975; Glick Hargreves & Drues, et al., 1976a, 1976b, 1976c). In the case of schizophrenic patients, those hospitalized for longer periods were functioning significantly better at discharge than at the time of admission, and they continued to improve after discharge. In the case of the non-schizophrenic patients, those who were hospitalized for a longer time were functioning as well as, but not noticeably better than, those in the short-term group at their respective discharge times. In this case, short-term treatment appeared to be as effective as long-term treatment for patients with less severe, less chronic or non-psychotic diagnoses.

In a study of students with less severe neurotic difficulties, both long- and short-term patients manifested better adjustment immediately following treatment; 43% of these clients indicated that the changes had been maintained at the time of follow-up. The investigators concluded that short-term treatment is appropriate for clients who are "not severely disturbed" (Keilson et al., 1979). For more severely disturbed, depressed patients it has been suggested that a brief intervention may be useful as a "first treatment" (Brockman et al., 1987). This

approach to treatment may prepare the client for later therapy aimed at dealing with personality dynamics by dealing first of all with the immediate symptoms of depression.

Relapse and Outcome

Those studies that focused only on the success of short-term treatment generally showed it to be helpful, although many studies reported relapse rates and offered suggestions to account for them. Gallagher-Thompson et al. (1990), in a study of major depression in the elderly, found that at the conclusion of short-term therapy, 52% of the clients were no longer clinically depressed. At 2 year follow-up 70% of subjects were no longer clinically depressed, although 22% continued to have a diagnosis of major depression. The investigators concluded that gains were maintained for those who were depression-free at the time of termination, but the prognosis was not favorable for those who still maintained a diagnosis of major depression at termination. This was supported by Simons, Murphy, Levine, and Wetzel (1986) in their study of response to short-term cognitive therapy or pharmacotherapy. Simons and associates differentiated between patients who had scores of 10 or higher on the Beck Depression Inventory (BDI) at the end of treatment (non-responders), patients who had scores of less than 10 at termination (responders), and responders who had scores of 16 or higher at any one of the follow-up visits (relapsers or recurrers). Twenty-eight of the 44 (63%) clients whose depression improved (responders) sustained this improvement. These results are discussed further on in this review.

Relapse tends to be a difficulty in the treatment of mental illness, especially when treating depression that is recurrent or chronic (Atwood & Chester, 1987). Cameron (1989) found that 26% of depressives had chronic depression, while Remick (1989) reported that 10% to 20% of depressive illness has a chronic course. Results indicated that anywhere from 25% (Keller, Shapiro, Lavori, & Wolfe, 1982) to 36% (Simons et al., 1986) of patients who had apparently recovered from depression at the time of termination relapsed within weeks or months of that time. Some (22% to 50%) had sought additional psychological or psychiatric care by the time of 12 month follow-up (Kovacs et al., 1981). Further, 17% of general psychiatry patients reapply for treatment each year (Goyne & Ladoux, 1973). These figures suggest that although short-term treatment is effective, it often does not prevent some patients from subsequent relapse. There were no comparable studies for long-term treatment, but some researchers have suggested that certain patients may need a longer period of time to assimilate changes (Cummings, 1977b; Hill et al., 1983) and that relapse occurs in some cases because therapy had been too brief.

Perhaps there are other variables that may be predictors of relapse such as a diagnosis of major depression superimposed over a more chronic depression (Dysthymia). Remick (1989) found that patients with a major depression superimposed on a dysthymic disorder recover to their mildly symptomatic state more rapidly than those patients with more acute episodic depression, though they are less likely to achieve full remission and more likely to experience relapse than

those with major depression alone. The symptoms of the major depression may abate while the underlying chronic depression remains untreated. It was also found that three or more previous episodes of major depression correlated highly with relapse (Keller et al., 1982; Kovacs et al., 1981) lending support to the idea that an underlying dysthymic depression may connect these more severe episodes. Thus, the choice of treating a patient in long-term or short-term psychotherapy may become a part of the clinician's treatment decision and plans based on the severity of the diagnosis, the presence of dysthymia and other variables (Ursano & Dressler, 1974) such as the number of presenting issues (Hill et al., 1983).

The relationship between treatment length and improvement in psychotherapy seems to be positive and linear until approximately 20 sessions. Clients appear to gain or show improvement when they remain in treatment for at least 20 sessions, after which improvement seems to level off (Strassberg et al., 1977; Weitz et al., 1975).

Several studies have reported no significant differences between short- and long-term groups in their level of improvement (Errera et al., 1967; Keilson et al., 1979). This suggests that sometimes clients are seen to improve equally with either short- or long-term treatment. However, clients sometimes show improvement in different areas based on the length of their treatment.

Some research has indicated that limiting the amount of time allowed for psychotherapy affects how the client responds to treatment. In one study comparing short- and long-term treatment conditions, the short-term group

exhibited greater improvement on scales measuring "inner directedness" and "self-acceptance," although both groups showed positive changes on all measures (Munro & Bach, 1975). It has been postulated that for inpatients, an earlier anticipated release from treatment may motivate the treatment team, the family and the patient to exert extra effort and thus speed up improvement (Glick, Hargreaves, Drues, et al., 1976a, 1976c). This is an idea supported by other proponents of short-term treatment who believe that patients will take as much time in therapy to get well as they infer they have. Patients in long-term treatment tend to act as if they have a lot of time to work and therefore do not always focus on their problems (Piper et al., 1984). This may be true of some patients who can benefit from short-term therapy, but as has been shown, there may be other patients who require additional time to get well. Differentiating between these patients may be the key to effective treatment of depression.

Factors Affecting Therapy Outcome

Most of the studies reviewed for this paper showed no clinical or demographic differences between those assigned to short- or long-term groups. However, other differences did emerge during therapy. Frank et al. (1984) differentiated between "normal, slow and non-responders" in a study of patients with a diagnosis of major depression. Although there were no visible clinical or demographic differences between the groups before treatment, biological differences emerged during treatment. Slow and non-responders were found to

have sleep onset problems, including lower REM density levels. That is, they would go to bed earlier, have more problems falling asleep and have more difficulty maintaining REM sleep. This is an area in which further testing is needed to enable clinicians to differentiate between clients who need extended time in treatment and those who are capable of responding more quickly.

Most other researchers who reported differences for clients who failed to respond to short-term therapy gave reasons other than biological differences for the failure. Those who responded to short-term treatment for depression were found to have less severe depression, better social adjustment, better overall emotional health, better social support networks, and to have been depressed fewer times and for a shorter period (Gallagher-Thompson et al., 1990; Rounsaville et al., 1981; Simons et al., 1986). These results were only mildly refuted in one study (Brockman et al., 1987) in which patients with a history of depression of less than six months duration showed similar changes to those with a longer history of depression. This study supported the conclusion, however, that patients who were more severely ill displayed less change than those less severely ill.

Stewart's (1972) study of his own patients' progress suggested that clients who responded well to short-term treatment for depression tended to be motivated, intelligent, able to work and to relate to others, and lacking extreme personality characteristics. He also noted that these patients were able to use psychological interpretations for their benefit at the initial interview. What is

interesting is that some of the characteristics listed by Stewart are in direct opposition to the diagnosis of depression. By definition, depressed patients are rarely motivated. Stewart reported that at the termination of his short-term work with depressed patients, 8 of 11 reported no change in their depressive symptoms. All of these characteristics describe, in general, patients who are less severely disturbed. It would appear to be common sense that the less the individual's personality structure is affected by psychopathology, the more rapidly he or she would be expected to respond to treatment. Luborsky et al. (1971) reported several client characteristics positively related to psychotherapeutic success, including intelligence, high functioning, motivation and the expectation that therapy will be helpful.

Another interesting idea is that the use of different therapeutic modalities may produce differences in how clients appraise their symptoms. Simons et al. (1986) suggested that the high relapse rate of those who were treated by means of pharmacotherapy as opposed to those who were treated by means of Cognitive Therapy may have been a result of how the patients were taught to view their symptoms. This idea is supported by others (Kovacs et al., 1981) who found that patients treated with Cognitive Therapy (as opposed to those treated with medication) reported significantly lower levels of depression at follow-up despite initial more rapid progress of those treated with medication. Clients in a treatment group who are taught that they have the capacity to deal with their problems themselves rather then depending passively on a substance may feel

greater control over their lives and thus not fall as easily into another depressive episode. This is consistent with theories of depression which incorporate learned helplessness as a major component of depressive illness.

Suggestions for Future Research

Future research on optimum time for successful treatment of depression should include the possibility of follow-up care after short-term treatment (Kovacs et al., 1981) and the possibility of a referral process based on whether the client's presenting problems are focal or multi-focal (Ursano & Dressler, 1974). Brockman et al. (1987) also suggested that patients showing symptoms of major depression should be treated pharmacologically before psychotherapy begins. Those with less severe depression, whose symptoms fail to recede after the first few sessions, should be also be treated medically while continuing in psychotherapy. Klerman (1989) reported results of studies conducted by the National Institutes of Mental Health which showed that psychotherapy alone (in this instance employing Interpersonal Psychotherapy) led to improved social functioning and interpersonal relations but had no effect on symptomatic relapse in depression. Those who relapsed were not helped without medication. Patients receiving pharmacotherapy in combination with psychotherapy showed better results over a longer period.

Both short-term and long-term treatment for depression may be valuable and beneficial. Most therapists see both as valuable for appropriate clients

(Luborsky, Singer, & Luborsky, 1975; Ursano & Dressler, 1977). Future research may need to focus on further understanding the characteristics of clients who respond better to a particular type of treatment. This would require more precise differentiation between types of depression and between short- and long-term treatments. The goals of therapy need to be better explained in terms that facilitate measurement of goals specific to long-term treatment. It would be helpful to develop a screening process which could lead to a better idea of an "optimum" number of sessions for a particular client (Keilson et al., 1979).

Summary and Conclusions

The treatment of depression is a complex matter in which success appears to depend on varying factors, including the severity of the depression, the individual's personality structure and personal history, biological factors, the modality of the therapist and the decision to use medication. This paper has focused on the issue of the time necessary for the successful treatment of depression. Though time is related to each of the factors mentioned above, it is difficult to extrapolate time as an individual factor in such a complicated treatment decision.

The research reviewed in this paper, based on outcome studies comparing long- and short-term treatments for depression, illustrates the problems of methodological weaknesses. Outcome often changes because of the types of measures used, how improvement is defined, whose evaluations are used, or at

what point in the treatment measurements are taken. It is unclear if time is part of the therapeutic equation. That is, it is not clear whether the theoretical approach behind long- or short-term therapy has a greater effect on outcome than does the passage of time alone.

From the studies reviewed, patients appear to respond differently to short- or long-term treatment, to approach their own treatment differently in terms of being more involved in short-term sessions. Patients in long-term treatment tend to agree more with their therapists about the goals of treatment.

Various studies produced very different results when it came to reporting the success of treatment. Some concluded that short-term is most effective, and some reported that long-term therapy is most effective. The most compelling evidence seemed to point to the idea that certain types of patients will receive greater benefit from long-term treatment while other types of patients will receive greater benefit from short-term psychotherapy. Those studies that considered relapse rates suggested strongly that some patients need therapy for longer periods of time than do others.

In many cases the research leaves room for questions. There are many methodological issues which, when not addressed, create conditions that make it difficult to be objective in evaluating long- and short-term treatments of depression. This may lead to biases in the results of such research. Even in the face of biases that appear to support the apparent success of short-term

treatment, it has not been demonstrated that long-term therapy is unnecessary, only that it may not always be the treatment of choice.

Both long-term and short-term therapy have been shown to be effective in the treatment of depression. The task facing future researchers is one of discovering the characteristics in each client that suggest the type of therapy that will be most beneficial in treating his or her unique experience of depression. The research that has been examined thus far seems to suggest that past history with depression, biological factors, the presence of few or many issues, general level of psychological health and the severity of present symptoms are among the factors that need to be considered when referring the individual for long- or short-term psychotherapy. Future researchers will need to identify these variables systematically and further define the patient characteristics that mesh successfully with short- or long-term psychotherapy.

Despite the success of short-term therapy in the treatment of many disorders, the research has not ruled out the necessity of making long-term treatment available for those patients who do not respond to other interventions. Cummings (1977a), in a summary of research conducted at a Kaiser-Permanente Clinic, concluded that providing short-term therapy for 85% of patients for whom it is effective makes long-term therapy economically feasible for the 10% for whom it is not only necessary but most effective as well. Five percent of patients were considered interminable, and no therapy was found to be effective. The next logical step in research is to effectively differentiate patients from one another and

thus move them into the form of treatment that would be most effective in treating their depressive symptoms.

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